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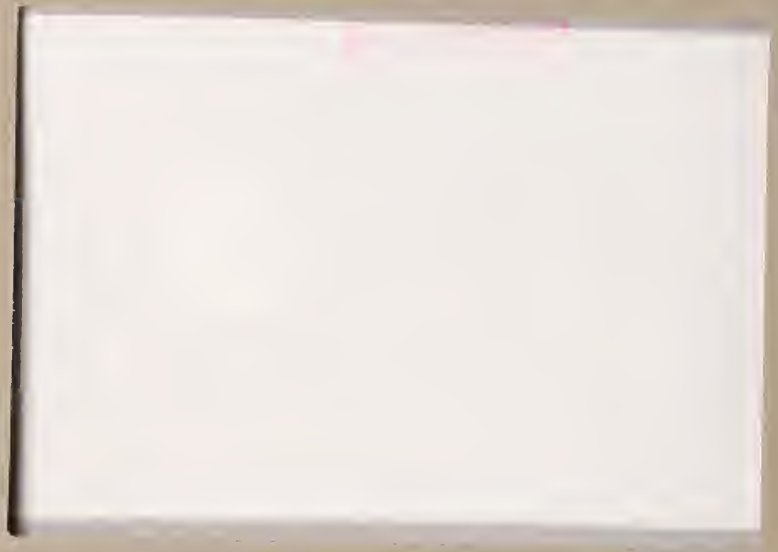
IMPACT OF MALPRACTICE INSURANCE COSTS ON PHYSICIAN PRACTICE, 1983-1986

FINAL REPORT

May 16, 1988

HEALTH ECONOMICS RESEARCH, INC.



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IMPACT OF MALPRACTICE INSURANCE COSTS ON PHYSICIAN PRACTICE, 1983-1986

FINAL REPORT

May 16, 1988

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1.0 INTRODUCTION AND SUMMARY

1.1 Motivation

The medical malpractice insurance "crisis" of the 1970s brought about widespread reforms to control the cost and assure the availability of malpractice insurance. State legislation was enacted in 49 states (excluding West Virginia). Two strategies were pursued (GAO, 1986a):

- creating new sources of insurance, including joint underwriting associations, reinsurance exchanges, physician and hospital-owned insurance companies, hospital self-insurance programs, and state administered excess-limits or patient compensation funds; and
- developing a new form of insurance policy, known as claims-made policies,* which would allow insurers to more reliably predict their losses and set premium levels.

To what extent is the United States involved in another crisis in the mid-1980s? According to a study by the General Accounting Office (1986a), frequent news reports were broadcast by the media in 1985 concerning rising premiums, claims incidence, and jury awards, changing practice patterns and caseloads to reduce risk, early retirements or specialty changes, and so on.

The 1987 Physicians' Practice Follow-up Study (PPFS) was conducted to obtain data on 1986 malpractice insurance premiums, liability coverage limits, perceived availability problems, and selected practice impacts. The physicians participating in the PPFS also participated in an earlier survey, the Physicians' Practice Costs and Income Survey (PPCIS), in which they provided data on malpractice insurance premiums in 1983. Data from the initial PPCIS and the Follow-up Survey enable us to compare the level of premiums in 1983 versus 1986, both in absolute terms and relative to physician gross incomes. To better understand the nature of the malpractice situation in the mid-1980s, we also address the following issues:

- Have physicians changed their liability coverage limits, perhaps due to increased claims incidence or higher settlements?
- Have physicians experienced problems with the availability of malpractice insurance, such as lack of certain types of coverage or withdrawal of carriers from their state?

*According to A Discursive Dictionary of Health Care (1976) a claims made policy "increases the accuracy of ratemaking...(T)he insured is covered for any claim made, rather than any injury occurring, while the policy is in force." Under an occurrence policy, "the insured is covered for any claims arising from an incident which occurred or is alleged to have occurred during the policy period, regardless of when the claim is made."

- Have physicians discontinued performing high-risk procedures, such as obstetrics or certain types of surgery?

- Have physicians discontinued treating certain types of cases, possibly creating access problems for selected types of patients?

1.2 Summary of Findings

This report examines trends in malpractice insurance premiums from 1983 to 1986 and the impact of rising malpractice insurance costs on physician practices. The 1987 Physicians' Practice Follow-up Survey, together with the 1983 Physicians' Practice Costs and Income Survey, are the only known sources of self-reported data from a panel of physicians across two points in time.

For the vast majority of physicians (90%), the malpractice insurance premium was paid solely by the physician or his or her practice. For 3 percent, the hospital paid the premium, while for 6 percent the physician/practice and the hospital shared the cost of the coverage. In 1986, 1 percent of physicians were uninsured for cases of medical malpractice. About one-fourth of these were never insured, while one-third of the "bare" physicians had discontinued their coverage since 1984.

In 1986, physician own malpractice payments averaged $14,780, about 6.2 percent of gross practice income. (By own malpractice payments we mean the amount paid by the physician or his or her practice.) Premiums were 75 percent higher in 1986 than in 1983 ($8,446 in 1983), but relative to gross income they were 57 percent higher (4.0% of gross in 1983). Malpractice insurance premiums rose faster than either the Consumer Price Index (10.1% from 1983 to 1986) or the Medical Care Index (21.3%).

Premiums ranged nearly five-fold across specialties, from $6,474 for internists to $31,180 for obstetrician/gynecologists (OBGs). Also at the low end (under $10,000) were general and family practitioners, other medical specialists (e.g., allergists, dermatologists), and ophthalmologists. At the high end of the range (over $20,000) were anesthesiologists, general surgeons, orthopedic surgeons, and other surgical specialties (e.g., cardiovascular/thoracic surgeons, plastic surgeons). Physicians with high premium costs in absolute terms also bore a high cost relative to their gross income.

From 1983 to 1986, premiums doubled for radiologists, other medical specialists, and OBGs. In fact, OBGs bore a much greater burden relative to their gross incomes, spending 10.8 percent of gross on malpractice insurance up from 6.3 percent in 1983.

Not only do premiums vary substantially across specialties, but also across the country, ranging from $9,760 in the West South Central region to $17,647 in the Middle Atlantic region. The largest premium increases -- roughly a doubling in costs -- occurred in the East and West South Central and East North Central regions.

In 1983, employed physicians spent proportionately less of their gross income on their own malpractice insurance compared to self-employed physicians. By 1986, however, the rates equalled or exceeded the average for self-employed physicians. For example, hospital employees experienced a doubling in their out-of-pocket premium expenses relative to gross incomes (from 2.6% to 6.2%), while clinic and HMO employees faced a tripling (from 2.5% to 7.3%).

The most common coverage limits (per case/total) in 1986 were $1 million/$3 million, reported by 42 percent of physicians. The second most common limits were $1 million/$1 million (11%), followed by $100,000/$300,000 and $200,000/$600,000 (6% each). Little variation was exhibited across specialties and practice arrangements.

Since 1983, one-in-three physicians changed their coverage limits, including 15 percent who increased and 17 percent who decreased their per case amount. Similarly, 16 percent increased and 20 percent decreased their total limit. From 1983 to 1986, the average per case limit rose from $984,000 to $1.1 million, a gain of 7.1 percent. The average total limit rose 7.4 percent, from just under $2.3 million to slightly more than $2.4 million.

When asked about problems with the availability of malpractice insurance, only 13 percent of physicians responded they had encountered a problem in obtaining insurance. About half reported a general availability problem such as (1) a carrier withdrew from the state, (2) they were denied coverage or their policy was cancelled, or (3) they felt there were not enough carriers to choose from. (Some of these problems, however, may have occurred during the 1970's "crisis".)

Another third were concerned about the availability of certain types of coverage, for example, restrictions on coverage limits, lack of umbrella coverage, lack of occurrence policies, or restrictions based on group size, specialty, or procedures performed. Another one-in-six physicians explicitly mentioned the cost of insurance as a problem (although this is not strictly an availability problem, but rather a willingness-to-pay issue).

Physicians were asked whether they had adopted negative defensive medicine practices, that is, discontinuing to perform certain procedures or to treat certain cases. Overall, 14 percent discontinued performing one or more procedures and 11 percent stopped treating certain cases in response to malpractice insurance costs.

We found that physicians were most likely to discontinue obstetrics (24%). General and family practitioners tended to cease all obstetrical practice, while OBGs discontinued their high-risk obstetrical practice (including the performance of Caesarean-section deliveries). Of those discontinuing all surgery, again general and family practitioners were disproportionately represented. By stopping surgery and/or obstetrics, general and family practitioners are placed in a lower risk category and charged a lower malpractice premium. Other responses to malpractice insurance costs include discontinuation of specific types of major or minor surgery, office surgery or surgical assisting, and referral of all high risk procedures.

Physicians most often discontinued seeing certain cases based on non-medical characteristics of patients. Two types of patients were most affected: patients involved in litigation, and Medicaid and indigent patients (each reported by 1% of all physicians, or 11% of physicians refusing certain cases). Surgeons were most likely to refuse patients involved in litigation, presumably because they perceived a higher risk that a malpractice claim would be made. Both surgeons and primary care physicians were likely to deny services to Medicaid patients, raising concerns about access to care among low-income patients. These findings raise questions, however, about the extent to which physicians' decisions to refuse Medicaid patients are motivated strictly by rising malpractice costs or perceived risk, or are also based, for example, on the level of Medicaid payments for obstetrics or other services.

Negative defensive medicine practices do not appear to be nearly as widespread as positive defensive medicine strategies. For example, Zuckerman (1986) found that physicians were likely to increase record-keeping (57%), increase patient referral (45%), perform additional tests (41%), and spend more time with patients (36%) to reduce the risk of malpractice suits.

1.3 Organization of Report

Chapter 2 describes the data and methods used in this report. Next, Chapter 3 compares malpractice insurance premiums in 1983 and 1986 in absolute terms and relative to gross income. Premiums are compared across specialties, regions, and practice arrangements. Chapter 4 presents data on common coverage limits carried by physicians and examines whether limits have changed from 1983 to 1986. Finally, Chapter 5 describes the impact of rising insurance costs in two areas: problems with the availability of malpractice insurance, and impact on physician practice patterns (i.e., discontinuation of certain procedures or cases).

2.0 METHODS

2.1 Data Source

This analysis is based on data from the Physicians' Practice Follow-up Survey (PPFS) conducted by NORC during the first six months of 1987, as well as from the 1984-85 Physicians' Practice Costs and Income Survey (PPCIS). Physicians participating in the initial PPCIS were asked follow-up questions on their practice arrangements, malpractice coverage, and Medicare participation. In addition, the interview included questions on the time and complexity involved in performing 10-15 selected medical or surgical procedures related to the particular specialty. Finally, surgeons were asked about the billing practices and office visit patterns associated with several surgical procedures.

The 1984-85 PPCIS included 4,729 physicians, with a response rate of 67.6 percent. The Follow-up Survey excluded physicians specializing in pediatrics, pathology, psychiatry, and a residual category referred to in the 1984-85 PPCIS as "all other specialties" (except neurologists who were included here).* The sample for the Follow-up Survey consisted of 3,554 physicians, of which 2,499 physicians (74.2 percent) completed the interview. The completion rate ranged from 57.4 percent among cardiologists to 83.3 percent among radiologists. Statistical weights used in the analysis included adjustments for non-response in the PPCIS and Follow-up Survey, as well as the disproportionate probability of selection.

Table 2-1 presents the total number of physicians in the sample by specialty as well as the number reporting own malpractice insurance premiums for both 1983 and 1986. Because of the small number of neurologists in our sample (n=26), estimates are not presented for this specialty separately but are included in the totals for all physicians.

Differences between means have been tested for statistical significance using a two-tailed t-test ($p < 0.05$).

2.2 Relevant Questionnaire Items

2.2.1 Analysis of Malpractice Insurance Premiums

Our analysis of changes in malpractice insurance premiums relies on data from both the initial survey and the Follow-up Survey, including the following:

*This residual category includes physicians specializing in emergency medicine, rehabilitation medicine, occupational medicine, and general preventive medicine.

TABLE 2-1

SAMPLE SIZES

Specialty	Number of physicians in sample[a]	Number of physicians reporting premiums for 1983 and 1986[b]
TOTAL	**2,499**	**1,882**
General practice	174	132
Family practice	334	258
Internal medicine	318	233
Cardiology	89	67
Other medical specialties[c]	194	131
General surgery	176	145
Orthopedic surgery	104	82
Ophthalmology	104	86
Urology	125	105
Obstetrics/gynecology	205	163
Other surgical specialties[d]	134	102
Anesthesiology	256	200
Radiology	250	159
Neurology[e]	36	19

[a]Reflects the number of physicians that participated in the Physicians' Practice Follow-up Survey.

[b]Reflects the number of physicians with own malpractice insurance premiums greater than zero for 1983 and 1986.

[c]Other medical specialties include allergy, immunology, dermatology, gastroenterology, nephrology, rheumatology, pulmonary diseases, oncology, and endocrinology.

[d]Other surgical specialties include cardiovascular/thoracic surgery, plastic surgery, neurological surgery, and otorhinolaryngology.

[e]Due to the small sample size, separate estimates have not been made for neurologists, but these physicians are included in the totals for all specialties.

Source: 1987 Physicians' Practice Follow-up Survey.

- malpractice insurance premiums ("own" and hospital payments);
- gross practice incomes; and
- practice size.

The Follow-up Survey questionnaire contains refinements to the initial survey, which should, on one hand, improve the data reported but on the other hand, may reduce the comparability between the two surveys. We compare the questionnaire content for each of these data elements.

Malpractice Insurance Premiums

Both surveys gathered data on malpractice insurance premiums paid by the physician (or practice) and the hospital. The initial survey asked:

- How much of (your/the practice's) total malpractice insurance was paid for by (HOSPITAL)?

  $_____OR HOSPITAL SELF-INSURED.....1

- How much did your practice pay in premiums for your own malpractice insurance during 1983?

  $_____

The corresponding questions from the Follow-up Survey are displayed in Exhibit 2-1. Three refinements have been made. First, physicians were asked how much was paid by "you or your practice," rather than simply "your practice." The intent was to clarify the scope of own malpractice payments. Second, a screener question on whether the hospital paid for the physician's own coverage was added to improve the reporting of hospital payments. The earlier survey asked about hospital payments only if a physician reported a specific hospital affiliation. Third, the Follow-up Survey explicitly verified whether a physician had no coverage (that is, own and hospital payments were equal to zero) or whether coverage was provided through hospital self-insurance.

Gross Practice Income

One segment of our analysis concerns the relationship of malpractice premiums to gross practice income. The two lead-in questions regarding gross practice income were as follows:

EXHIBIT 2-1

QUESTIONNAIRE CONTENT: MALPRACTICE INSURANCE PREMIUMS, 1986

INTERVIEWER: SEE Q.9D1. IN THIS SECTION, USE "1986" IF R REPORTED 1986 INCOME. USE "1985" IF R REPORTED 1985 INCOME.

Now I'd like to ask you a few questions about malpractice insurance.

10A. First, how much did you or your practice pay in premiums, for your own malpractice insurance, during (1986/1985)?

_____

10B. Did your hospital pay any premiums, for your own malpractice insurance during (1986/1985)?

Yes.....(ASK Q.10C).....1
No.....(SKIP TO Q.11).....2

10C. How much did your hospital pay on your behalf in premiums, during (1986/1985)?

_____

IF Q.10A CODED "0" AND Q.10B CODED "NO," ASK Q.11; OTHERWISE SKIP TO Q.12.

11. During (1986/1985) did your hospital provide you with coverage through a self-insurance program or were you not insured?

Hospital provided coverage.....(GO TO Q.12)....1
Not insured.....(ASK A).....2

A. In what year did you discontinue your malpractice coverage?

_____

IF VOLUNTEERED: Never insured.....1

Source: 1987 Physicians' Practice Follow-up Survey.

- Initial Survey: In 1983, what was (your gross income from medical practice/the gross income from the entire practice) before practice deductions and taxes?

- Follow-up Survey: In 1986, what was (your personal gross income from medical practice/the gross income from the entire medical practice) before practice deductions and taxes?

The wording in parentheses was substituted according to the physician's employment arrangement with the first phrase used for employed physicians and the second for self-employed physicians. The Follow-up Survey clarified the first phrase by changing the wording to "your personal gross income." However, the main difference between the two surveys concerns the level of detail preserved on gross income. The initial survey coded gross income into 19 income categories (regardless of whether or not the physician was able to report a precise estimate of gross income), although physicians grossing over one million dollars were asked for the actual amount. In the Follow-up Survey, detail on actual gross practice income was preserved; however, physicians who were unable or unwilling to report the exact amount were asked for the range. Again, physicians grossing more than one million dollars were asked for the amount.

In the initial survey, we found that some self-employed physicians in group practice were unable to report the gross income from the entire practice but instead reported gross personal income. Therefore, to assist in standardizing gross practice income on a "per physician" basis, the Follow-up Survey explicitly asked whether the reported income amount was (1) practice gross, (2) personal gross, (3) personal net, or (4) other.

Practice Size

To standardize gross practice income on a per-physician basis, we divided by practice size. These questions were essentially the same in the two surveys. The Follow-up Survey asked:

- During 1986, how many physicians including yourself were formally associated with your practice for at least 20 hours a week? PROBE FOR MAIN PLACE OF EMPLOYMENT.

  _____PHYSICIANS

- During 1986, how many other physicians were associated with your practice for less than 20 hours a week? PROBE FOR MAIN PLACE OF EMPLOYMENT?

  _____PHYSICIANS

Three main changes have been made. First, the initial survey asked about practice size at the time of interview (1984-85), while malpractice premiums and gross income referred to 1983. In the Follow-up Survey practice size, premiums, and income were collected for 1986. Second, the Follow-up Survey clarified for the interviewers and physicians that practice size should relate to the main place of employment, for physicians with multiple arrangements. Third, the wording in the Follow-up Survey indicates "how many physicians including yourself were formally associated with your practice..." This simply clarifies that the count of full-time physicians should include the responding physician.

2.2.2 Analysis of Malpractice Insurance Coverage Limits

Exhibit 2-2 displays questions from the Follow-up Survey related to liability limits. Physicians were first asked about their per case and total limits in 1986 and then asked about the limits in 1983. Physicians who were unable to recall their 1983 coverage limits were asked whether the limits had increased, decreased, or stayed the same.

2.2.3 Analysis of Malpractice Insurance Availability and Practice Impacts

The Follow-up Survey included three questions about the availability of malpractice insurance and impact of malpractice insurance costs on physician practice:

- Have you ever had any problems with the availability of malpractice insurance? (IF YES, PROBE: What problems have you had?)
- Since this time last year, have you discontinued performing certain high-risk procedures because of malpractice insurance costs? (IF YES, PROBE: What procedures have you discontinued?)
- Since this time last year, have you discontinued seeing certain types of cases because of malpractice insurance costs? (IF YES, PROBE: What types of cases have you discontinued?)

Physicians who reported an availability problem or practice impact were probed as to the nature of the problem or the extent of the impact. The verbatim responses to these open-ended questions were recorded by the interviewer and have been recoded for purposes of analysis. The next section discusses the coding of open-ended questions.

EXHIBIT 2-2

QUESTIONNAIRE CONTENT: CHANGES IN MALPRACTICE LIABILITY COVERAGE LIMITS, 1983-1986

INTERVIEWER: IN THE FOLLOWING QUESTIONS THE DOCTOR MAY GIVE YOU LIMIT PER CASE AND TOTAL LIMIT COMBINED (E.G. 100/300, 200/500). LIMIT PER CASE IS USUALLY FIRST, AND SHOULD BE SMALLER THAN TOTAL LIMIT. ALWAYS PROBE TO RESOLVE AMBIGUITIES.

12. What was the limit per case on your malpractice liability coverage for (1986/1985)?

_____

13. And what was the total limit on your malpractice liability coverage for (1986/1985)?

_____

14. What was the limit per case on your malpractice liability coverage for 1983?

_____

IF "DON'T KNOW" TO Q.14, ASK Q.14A. OTHERWISE GO TO Q.15.

14A. Between 1983 and (1986/1985), did the limit per case on your malpractice liability coverage increase, decrease, or stay the same?

Increased.....1
Decreased.....2
Same as 1983.....3

15. And what was the total limit on your malpractice liability coverage for 1983?

_____

IF "DON'T KNOW" TO Q.15, ASK Q.15A. OTHERWISE, GO TO Q.16

15A. Between 1983 and (1986/1985), did the total limit on your malpractice liability coverage increase, decrease, or stay the same?

Increased.....1
Decreased.....2
Same as 1983.....3

Source: 1987 Physicians' Practice Follow-up Survey.

2.3 Coding of Open-Ended Questions

The 1986 Follow-up Survey contained three sets of open-ended questions that required manual coding prior to analysis (see Section 2.2.3 above). The open-ended coding was performed by Health Economics Research, based on computer listings of verbatim responses generated by NORC.

Two approaches were available for collecting data on malpractice insurance availability and practice impacts. The deductive method involves specifying a priori a set of response categories while the inductive method allows the respondents complete latitude in answering an open-ended question. The inductive method was chosen for two reasons. First, obtaining physicians' verbatim responses reduces the bias inherent in forcing the respondent to adapt to a preconceived list of categories. Second, such responses are often more detailed and diverse than fixed alternative responses, providing more insight into the decision-making process of physicians. However, a tradeoff is inevitable: while such an approach preserves the diversity and richness of the response, some reliability in the coding process may be sacrificed.

Because these questions were fielded for the first time, our first task was to develop a coding scheme. A number of precautions were taken to preserve the depth and reliability of the data (Nachmias and Nachmias, 1976). First, more categories (rather than fewer) were specified at the outset, because aggregating groups is easier than splitting them. Second, we designed the dimensions of the coding schemes for each question so as to capture details suggested by our understanding of the issues. For instance, in examining physician problems with the availability of insurance we wanted to distinguish between cost and other factors such as the withdrawal of all carriers from a state. Also, in examining whether physicians had discontinued certain types of cases, we wanted to distinguish between medical and non-medical characteristics of patients, both of which might lead a physician to view them as a higher malpractice risk. Third, all categories were defined as mutually exclusive and exhaustive.

Some physicians provided multiple responses to the open-ended questions; up to three responses were coded per physician. The following table shows the frequency of multiple responses:

	Availability Problems	Discontinued Procedures	Discontinued Cases
One response	282	246	208
Two responses	41	84	50
Three responses	3	13	9

Multiple responses were most common with respect to procedures that were discontinued due to malpractice insurance costs. We have weighted multiple responses by one-half (two responses) or one-third (three responses) to simplify the analysis.

Appendix A displays the categories of the open-ended coding schemes together with examples of responses in each category.

2.4 Data Preparation

The data presented in this report required substantial editing prior to analysis. First, some physicians reported malpractice premiums for the entire practice rather than their own malpractice premiums. In such cases, the practice premium was divided by the number of physicians in the practice to obtain an amount per physician. Second, we converted gross practice revenues from a categorical variable to a continuous variable by taking the midpoint of the range. The same ranges (and midpoints) were used in the 1983 and 1986 surveys. Some physicians reported gross revenues for the entire practice, while others reported their personal gross income. We inspected outlier cases to determine whether revenues should be divided by practice size. We used several measures to detect outliers: (1) comparing 1983 gross and net incomes; (2) comparing 1983 and 1986 gross incomes; and (3) examining malpractice premiums in relation to gross income.

Third, we checked the liability coverage limits for internal consistency. The "per case" limit should be less than or equal to the "total" limit. We found a number of data entry errors simply because the interviewer entered the wrong number of zeroes. For example, if the reported limits per case/total were $1 million/$300,000 for 1983 and $1 million/$3 million for 1986 the total amount for 1983 was changed to $3 million.

Fourth, we screened the data for outliers. All outlier checks were performed by specialty. A reported value was considered an outlier if it was more than two times the next highest number. Outliers were set to missing for the analysis. These data editing and cleaning procedures resulted in the exclusion of 20 cases from the analysis.

Chapter 3 compares changes in malpractice premiums from 1983 to 1986 both in absolute terms and as a percent of gross income. To produce more comparable means, the analysis is based on physicians who reported premiums and gross incomes for both time periods. We investigated the possibility of using imputed data for missing values on 1983 own malpractice premiums and 1983 gross practice revenues. Under the previous contract for the 1983 Physicians' Practice Costs and Income Survey (PPCIS), missing data were imputed using "nearest neighbor" techniques (see Sprachman, Rosenbach, Burich,

et al., (1985) for details). Upon comparing the imputed malpractice premiums for 1983 to self-reported premiums for 1986, we realized that the imputation technique may have overestimated 1983 physician premiums. Whereas 14 percent of the physicians reporting premiums for both years had higher premiums in 1983 than in 1986, 28 percent of the imputed 1983 values were higher than the self-reported values for 1986.

Prior to analysis we also examined changes in employment arrangements from 1983 to 1986. We intended to examine premium changes and behavioral responses separately for those who had changed employment since 1983. About one-in-four physicians reported a different employment arrangement in 1986 versus 1983. Many of these physicians were in practices with the identical number of physicians. Upon closer investigation we identified 153 physicians (6% of the sample) who most likely changed practices, based on the following criteria:

- change in zip code;
- substantial change in practice size;
- verbatim comment in 1983 or 1986 survey indicating employment change;
- change from hospital employee to self-employed solo practice.

The remaining physicians may have been confused about the terms used in the survey to describe the employment settings and reported inconsistently over the two time periods. Their perception may have changed or the organization of their practice may have changed. In particular, we found a large proportion of physicians who reported they were self-employed in 1983 and employed by another physician or corporation in 1986, and vice versa. We do not consider this a change in employment arrangement.*

Data presented in this report by employment arrangement reflect the physician's self-reported status at the time of the follow-up interview. We have not omitted physicians who changed their employment arrangement between 1983 and 1986 for several reasons: (1) we did not find a higher incidence of missing data among those who changed; (2) liability limits were not more likely to increase or decrease; and (3) premium changes were not significantly higher both in absolute terms and relative to gross income.

*NORC recontacted seven physicians who made such a switch; two had changed practices while five had a different perception of their employment status in the Follow-up Survey.

3.0 CHANGES IN MALPRACTICE INSURANCE PAYMENTS, 1983-1986

3.1 Introduction

Is the U.S. in the midst of a medical malpractice crisis due to escalating insurance costs? This chapter provides baseline data on the nature and extent of malpractice insurance cost increases from 1983 to 1986. Specifically, we address the following issues:

- Who pays for physicians' medical malpractice insurance coverage? To what extent is the cost borne by the physician (or the practice) or shared with the hospital?
- Are physicians discontinuing malpractice insurance coverage due to high costs -- what percent of physicians are going "bare"?
- How much do physicians pay for their own malpractice insurance coverage?
- How much has the cost of malpractice insurance risen since 1983?
- To what extent does the cost of insurance vary by specialty, practice arrangement, and geographic location?

Section 3.2 provides an overview of "who pays the premium." Section 3.3 examines interspecialty differences in cost increases (both in absolute terms and relative to gross income), while Section 3.3 focuses on the geographic variation in costs from 1983 to 1986. Finally, Section 3.4 describes the differences according to practice arrangement.

3.2 Who Pays the Premium?

For the vast majority of physicians (90%), the malpractice premium was paid solely by the physician or his or her practice (see Table 3-1). For 3 percent, the hospital bore responsibility for paying the premium, while for 6 percent, the physician/practice and the hospital shared the cost of the coverage. Hospital coverage may be provided through a commercial policy or through self-insurance.

In 1986, 1 percent of physicians were uninsured for cases of medical malpractice. About a fourth of these physicians were never insured, while the remainder discontinued their policy during the malpractice "crisis" of the 1970s or more recently. One-third of the "bare" physicians had discontinued their coverage since 1984.

TABLE 3-1

SOURCES OF PAYMENT FOR MALPRACTICE INSURANCE PREMIUMS

	SOURCES OF PAYMENT			
	Physician or Practice (1)	Hospital[a] (2)	Both Physician and Hospital (3)	No Coverage (4)
ALL PHYSICIANS	**90.3%**	**3.0%**	**5.7%**	**1.0%**
Specialty				
General practice	90.5	1.1	4.2	4.3
Family practice	92.2	2.3	3.9	1.6
Internal medicine	88.7	5.1	5.9	0.3
Cardiology	84.7	5.4	8.3	1.6
Other medical specialties	86.7	4.3	8.1	0.9
General surgery	90.4	2.8	4.9	1.8
Orthopedic surgery	94.9	0.8	4.3	0.0
Ophthalmology	96.0	2.1	2.0	0.0
Urology	96.2	0.8	3.0	0.0
Obstetrics/gynecology	89.3	2.4	7.8	0.5
Other surgical specialties	90.3	2.5	6.5	0.8
Anesthesiology	92.4	2.3	5.0	0.4
Radiology	88.6	3.4	8.0	0.0
Practice Arrangement				
Self-employed	95.9%	0.4%	2.6%	1.1%
Employed by:				
Hospital or university	44.8	23.8	30.6	0.8
Clinic or HMO[b]	65.2	15.6	19.1	0.0
Another physician or corporation	92.0	2.0	5.3	0.6

[a]Includes coverage through hospital self-insurance.

[b]For clinic/HMO employees, columns (2) and (3) may reflect payments by the employer (i.e., clinic, HMO), not necessarily the hospital.

Source: 1987 Physicians' Practice Follow-up Survey.

Table 3-1 also displays the source of payment by specialty. The dominant payment source across all specialties was practice revenues. We might expect hospitals to defray the cost of malpractice premiums for the two hospital-based specialties -- radiology and anesthesiology -- but this does not appear to be the case.

Although obstetrician/gynecologists have by far the highest malpractice premiums on average, nine-in-ten paid for their insurance coverage entirely out of practice revenues. The cost was defrayed by hospitals (either in whole or in part) for only one-in-ten obstetrician/gynecologists.

The sources of payment for malpractice premiums clearly vary by practice arrangement. Self-employed physicians as well as those employed by another physician or corporation were most likely to pay the malpractice insurance premiums out of practice revenues. Among those employed by a hospital or university, the premium was more often paid by the hospital in its entirety (24%) or shared by the practice and hospital (31%). In only 45 percent of cases was the physician (or the practice) solely responsible for paying the premium. About a third of clinic or HMO employees paid the premium out of pocket, while another third received malpractice insurance coverage as a fringe benefit with either full (16%) or partial (19%) payment by the employer.

The remainder of this chapter focuses on <u>own</u> malpractice insurance payments made by the physician or his or her practice.

3.3 Interspecialty Differences

In 1986, physician own malpractice payments averaged $14,780, about 6.2 percent of gross practice income (Table 3-2). Premiums were 75 percent higher in 1986 than in 1983 ($8,446 in 1983), but relative to gross income they were only 57 percent higher (4.0% of gross in 1983). Malpractice insurance premiums rose faster than other prices, as measured by the Consumer Price Index (CPI) and the Medical Care Index (MCI). From 1983 to 1986, the CPI rose 10.1 percent, while the MCI rose 21.3 percent.*

Premiums ranged nearly five-fold across specialties, from $6,474 for internists to $31,180 for obstetrician/gynecologists (OBGs). Also at the low end (under $10,000 on average) were general and family practitioners, other medical specialists (e.g., allergists, dermatologists), and ophthalmologists. At the high end of the range (over $20,000) were anesthesiologists, general surgeons, orthopedic surgeons, and other surgical specialties (e.g., cardiovascular/thoracic surgeons, plastic surgeons).

*Figures for 1983 were obtained from the <u>Statistical Abstract of the U.S. 1987</u>, 1986 national annual averages were obtained from the Boston regional office of the Bureau of Labor Statistics.

TABLE 3-2

INTERSPECIALTY DIFFERENCES IN OWN MALPRACTICE INSURANCE PAYMENTS, 1983-1986[a,b]

	AVERAGE OWN MALPRACTICE PAYMENTS			OWN MALPRACTICE PAYMENTS AS A PERCENT OF GROSS INCOME		
Specialty	1983	1986	% Change	1983	1986	% Change
ALL PHYSICIANS	**$8,446**	**$14,781**	**75.0%**	**4.0%**	**6.2%**	**57.2%**
General practice	4,457	6,658	49.4	3.3	4.4	33.5
Family practice	4,138	7,535	82.1	3.0	5.0	65.8
Internal medicine	3,684	6,474	75.7	2.4	3.6	49.9
Cardiology	7,288	11,145	52.9	3.1	5.0	48.2
Other medical specialties	3,818	7,825	105.0	2.1	3.2	56.4
General surgery	11,850	21,073	77.8	6.4	8.8	37.3
Orthopedic surgery	15,563	26,348	69.3	5.6	8.1	44.1
Ophthalmology	5,614	9,423	67.8	2.3	2.9	26.1
Urology	8,664	15,953	84.1	3.4	6.1	76.7
Obstetrics/gynecology	15,230	31,180	104.7	6.3	10.8	72.1
Other surgical specialties	15,315	25,204	64.6	4.5	7.8	74.0
Anesthesiology	13,759	20,193	46.8	5.6	8.9	59.5
Radiology	5,864	11,320	93.0	2.3	3.9	70.8

[a]Own malpractice payments refer to payments made by the physician or the physician's practice. Excludes payment made by the hospital on the physician's behalf.

[b]Includes physicians with own malpractice payments.

Source: 1987 Physicians' Practice Follow-up Survey.

Physicians with high premium costs in absolute terms also bore a high cost relative to their gross income. For example, the five specialties averaging more than $20,000 in own malpractice insurance costs paid about 8 percent or more of their gross revenues towards insurance coverage. In contrast, those paying under $10,000 spent 5 percent or less of their gross incomes towards malpractice insurance. In other words, physicians do not seem to compensate for their high premiums by grossing higher revenues.

From 1983 to 1986, malpractice insurance premiums increased about 50 percent among general practitioners, cardiologists, and anesthesiologists. However, premiums doubled for radiologists, other medical specialists, and OBGs. Whereas in 1983, orthopedists, OBGs, and other surgical specialists averaged about $15,000 in premium costs, OBGs had exceeded the other two specialties by $5,000 to $6,000 in 1986. OBGs also bore a greater burden relative to their gross incomes, spending 10.8 percent on malpractice insurance, up from 6.3 percent in 1983. Ophthalmologists, on the other hand, experienced only a 26 percent increase in malpractice insurance costs relative to their gross incomes (despite a 68% cost increase) suggesting that their incomes were able to keep pace with rising practice costs compared to physicians in other specialties.

Much has been written about the malpractice insurance "crisis" in obstetrics. The GAO (1986), for example, documented the huge interstate variations in premium costs as of July 1, 1985. In Florida, OBGs paid $51,112, while those in South Carolina paid $6,922.* Paxton (1986) reports that 44 percent of OBGs who have discontinued obstetrics in the past ten years did so because of escalating premiums; 49 percent stopped delivering babies because of fear of suits. According to the AMA's Socioeconomic Monitoring System (1986), OBGs were more likely than other specialists to be sued: 64 percent of OBGs (vs. 36.5% of physicians overall) have been sued at least once during their career, including 21 percent in 1985 alone. In addition, OBGs have the highest annual incidence of claims, averaging 26.6 claims per 100 physicians in 1985 (vs. 10.1 claims for physicians overall).

3.4 Geographic Variation

Not only do premiums vary substantially across specialties, but also across the country. In 1986, premiums were lowest in the West South Central region ($9,760 on average) and highest in the Middle Atlantic region ($17,647), with an 81 percent differential (Table 3-3). Relative to gross incomes, malpractice premiums were also at the extremes in these two areas of

*These amounts reflect the most common policy issued by the largest carrier in the state.

TABLE 3-3

GEOGRAPHIC VARIATION IN OWN MALPRACTICE INSURANCE PAYMENTS, 1983-1986[a,b]

Region	AVERAGE OWN MALPRACTICE PAYMENTS			OWN MALPRACTICE PAYMENTS AS A PERCENT OF GROSS INCOME		
	1983	1986	% Change	1983	1986	% Change
ALL PHYSICIANS	**$8,446**	**$14,781**	**75.0%**	**4.0%**	**6.2%**	**57.2%**
New England	$7,248	$13,145	81.4%	4.6%	5.9%	26.4%
Middle Atlantic	10,461	17,647	68.7	5.1	7.5	45.5
South Atlantic	8,040	13,959	73.6	3.8	6.3	64.5
East North Central	6,671	13,048	95.6	2.9	6.1	114.8
East South Central	8,267	16,672	101.7	3.9	6.8	76.4
West North Central	6,405	12,590	96.6	3.4	4.8	41.6
West South Central	5,738	9,760	70.1	2.9	4.0	39.9
Mountain	7,800	14,156	81.5	4.1	7.3	76.0
Pacific	10,800	16,011	48.3	4.2	6.2	45.7

[a]Own malpractice payments refer to payments made by the physician or the physician's practice. Excludes payment made by the hospital on the physician's behalf.

[b]Includes physicians with own malpractice payments.

Source: 1987 Physicians' Practice Follow-up Survey.

the country, ranging from 4.0 percent of gross in the West South Central states to 7.5 percent of gross in the Middle Atlantic states.

From 1983 to 1986 own malpractice insurance premiums increased 75 percent overall (Table 3-2), but this increase was uneven across regions. For example, physicians in the Pacific region experienced only a 50 percent increase, from $10,800 to $16,011, although premiums in these states remained among the highest in the country (along with the East South Central and Middle Atlantic states). The largest premium increases -- roughly a doubling in costs -- occurred in the East and West South Central and East North Central regions.

By 1986, malpractice insurance payments accounted for a larger share of gross income than three year earlier. However, the increase was felt disproportionately in the East North Central states where the relative share more than doubled (from 2.9% to 6.1% of gross). In five regions, the relative increase was less than 50 percent, including New England with only a 26 percent increase (from 4.6% to 5.9% of gross). Physicians' gross incomes in these five areas apparently kept closer pace with premium increases.

3.5 Practice Differences

In 1986, hospital employees spent $10,149 for their own malpractice insurance coverage, about $4,000 to $6,000 less than physicians in other employment arrangements (Table 3-4). In large part, this may be attributed to the defrayal of some costs by the hospital (recall Table 3-1). Although hospital employees paid less than other physicians in absolute terms, their payments relative to gross income (6.2%) were comparable to other physicians.

Compared to 1983, hospital employees experienced a 62 percent increase in their out-of-pocket premium expenses, less than all other physicians. However, the picture looks quite different in relation to their gross income -- the rate more than doubled from 2.6 to 6.2 percent of gross. For clinic and HMO employees, the premium nearly tripled in relation to gross income from 2.5 to 7.3 percent of gross, with this group spending the highest proportion of gross income on malpractice premiums. However, as we will discuss in Chapter 4, clinic and HMO employers carry more extensive coverage, on average. Whereas in 1983 employed physicians spent proportionately less of their gross income on their own malpractice insurance compared to self-employed physicians, by 1986 the rates equalled or exceeded the average for self-employed physicians.

TABLE 3-4

PRACTICE DIFFERENCES IN OWN MALPRACTICE INSURANCE PAYMENTS, 1983-1986[a,b,c]

	AVERAGE OWN MALPRACTICE PAYMENTS			OWN MALPRACTICE PAYMENTS AS A PERCENT OF GROSS INCOME		
Practice Arrangement	1983	1986	% Change	1983	1986	% Change
ALL PHYSICIANS	**$8,446**	**$14,781**	**75.0%**	**4.0%**	**6.2%**	**57.2%**
Self employed	$8,460	$14,771	74.6%	4.1%	6.3%	51.1%
Employed by:						
Hospital or university	6,264	10,149	62.0	2.6	6.2	140.5
Clinic or HMO	9,190	15,771	71.6	2.5	7.3	192.6
Another physician or corporation	8,925	16,429	84.1	3.6	5.8	61.7

[a]Own malpractice payments refer to payments made by the physician or the physician's practice. Excludes payment made by the hospital on the physician's behalf.

[b]Includes physicians with own malpractice payments.

[c]Practice arrangement at time of follow-up interview.

Source: 1987 Physicians' Practice Follow-up Survey.

4.0 CHANGES IN LIABILITY COVERAGE LIMITS, 1983-1986

4.1 Introduction

Malpractice insurance policies, like other forms of liability coverage, contain limits on the amounts insurers will pay per occurrence (that is, for each case against the insured) and in the aggregate during the policy period. A common level of coverage is $1 million/$3 million, where the insurer will pay up to $1 million "per case" and $3 million "total." Coverage may be purchased in layers to assure sufficient coverage against medical malpractice claims. The first layer, basic coverage, may be augmented if the company's maximum limit is deemed to be low, either under state law, based on institutional requirements, or some other criterion. Excess coverage would be purchased from another company or from a state-operated catastrophic loss fund. Pennsylvania, for example, requires that physicians carry a basic policy of $200,000/$600,000 from an insurance company, supplemented by excess coverage of $1 million/$3 million from the state fund, for a combined coverage limit of $1.2 million/$3.6 million. The third layer, umbrella coverage, is a single policy covering professional, personal, and premises liability that is drawn on when the total limits of underlying policies are exhausted.

This chapter first presents the most common coverage limits in 1986, by physician specialty and practice arrangement. Then, the policy limits in 1983 are compared to those in 1986 to determine whether physicians have increased or decreased limits or maintained the same coverage. The coverage limits presented in this chapter are presumed to refer to basic coverage, although many physicians volunteered that they also carry an umbrella policy of $1 million, $5 million, or even more. In addition, physicians in Pennsylvania frequently commented that their basic coverage is supplemented by excess coverage mandated by state law.

4.2 Common Coverage Limits

The most common coverage limits (per case/total) on medical malpractice policies were $1 million/$3 million (Table 4-1). Two-in-five physicians had such coverage. The second most common limits were $1 million/$1 million (11% of physicians), followed by $100,000/$300,000 and $200,000/$600,000 (6% each). Altogether, the four most common policies accounted for two-thirds of physicians, suggesting that there is a high degree of consistency in the policy limits. Among the remaining third, however, the variation is quite extensive.

TABLE 4-1

COMMON COVERAGE LIMITS BY SPECIALTY AND PRACTICE ARRANGEMENT, 1986[a,b]

	FIRST		SECOND		THIRD	
	Limits	% of MDs	Limits	% of MDs	Limits	% of MDs
ALL PHYSICIANS	**$1.0/$3.0**	**42.4%**	**$1.0/$1.0**	**10.5%**	**$0.1/$0.3**	**5.8%**
					0.2/0.6	5.7
Specialty						
General practice	1.0/3.0	27.1	0.1/0.3	12.9	1.0/1.0	12.3
Family practice	1.0/3.0	32.5	1.0/1.0	14.7	0.1/0.3	7.9
					0.2/0.6	7.9
Interal medicine	1.0/3.0	50.9	1.0/1.0	7.9	c	
Cardiology	1.0/3.0	45.9	1.0/2.0	8.1	0.1/0.3	5.4
Other medical specialties	1.0/3.0	50.7	0.2/0.6	10.8	1.0/1.0	8.1
General surgery	1.0/3.0	44.4	1.0/1.0	14.8	0.1/0.3	6.3
Orthopedic surgery	1.0/3.0	51.3	1.0/1.0	12.2	c	
Ophthalmology	1.0/3.0	43.4	1.0/1.0	9.1	0.1/0.3	6.1
					0.2/0.6	6.1
Urology	1.0/3.0	46.1	0.1/0.3	7.9	0.5/1.0	6.6
					1.0/1.0	6.6
Obstetrics/gynecology	1.0/3.0	44.4	1.0/1.0	9.2	0.2/0.6	6.1
Other surgical specialties	1.0/3.0	42.4	1.0/1.0	7.9	0.2/0.6	7.2
Anesthesiology	1.0/3.0	42.0	1.0/1.0	12.7	1.0/2.0	5.9
Radiology	1.0/3.0	36.9	1.0/1.0	9.2	0.2/0.6	7.3
Practice Arrangement						
Self-employed	1.0/3.0	42.5	1.0/1.0	11.1	0.1/0.3	6.1
					0.2/0.6	6.1
Employed by:						
Hospital or university	1.0/3.0	44.6	1.0/1.0	9.8	0.1/0.3	6.5
Clinic or HMO	1.0/3.0	47.2	5.0/5.0	6.6	1.0/5.0	5.7
Another physician or corporation	1.0/3.0	39.2	1.0/1.0	8.6	1.0/5.0	5.4

[a]Coverage limits in millions of dollars. The first amount represents per case limit; the second amount represents total limit.

[b]Represents the three most common coverage limits. Percents sum to less than 100 percent due to other, less common combinations. A fourth combination is listed when the percentages were identical for the third and fourth limits.

[c]No other single policy limits accounted for at least 5 percent of physicians.

Source: 1987 Physicians' Practice Follow-up Survey.

Within specialty, there was little variation in coverage limits. The most common limit for all specialties was $1 million/$3 million, ranging from 27 percent of general practitioners to 51 percent of internists, other medical specialists, and orthopedists. For most specialties, the second most common limit was $1 million/$1 million, although general practitioners, urologists, and other medical specialties tended to have lower coverage (either $100,000/$300,000 or $200,000/$600,000), while cardiologists had a higher total limit ($1 million/$2 million).

Policy limits do not vary substantially by practice arrangement, although physicians employed by a clinic or HMO appear to carry more coverage. For example, the second and third most common policies were $5 million/$5 million (7%) and $1 million/$5 million (6%). In fact, the average limits for clinic and HMO employees ($1.3 million/$2.9 million) were significantly higher than those for self-employed physicians ($1.0 million/$2.4 million). (See Table 4-3.)

4.3 Changes in Limits

Physicians may raise or lower coverage limits in response to various pressures. On one hand, they may lower the coverage limits to reduce the cost of malpractice insurance. On the other hand, they may increase the limits due to increases in the number of medical malpractice claims filed by patients. In some cases, policy limits are beyond the physician's control. For example, the carrier may offer a very limited selection of coverage limits; the state may mandate a higher level of coverage than the physician had been carrying; or a hospital may impose certain requirements in exchange for admitting privileges.

Since 1983, one-in-three physicians changed their coverage limits, including 15 percent who increased and 17 percent who decreased their per case amount (Table 4-2). Similarly, 16 percent increased and 20 percent decreased their total limit. Little variation occurred across specialties and practice arrangement. Cardiologists, however seemed more likely to change their limits including 23 percent who increased and 21 percent who decreased their limits per case. Physicians employed by hospitals, clinics or HMOs seemed more likely to increase their limits, compared to those employed by another physician or corporation or self-employed.

Table 4-3 shows the average limits per case and total by specialty and practice arrangement. From 1983 to 1986 the average per case limit rose from $984,000 to $1.1 million, a gain of 7.1 percent. The average total limit rose 7.4 percent, from just under $2.3 million to slightly more than $2.4 million. Few significant differences were noted within specialty or practice arrangement. Family practitioners raised their total limit by 16 percent, on average. Self-employed physicians raised their total limit by 7 percent.

TABLE 4-2

CHANGES IN LIABILITY COVERAGE LIMITS, 1983-1986

	PER CASE LIMIT			TOTAL LIMIT		
	Increased	Decreased	Same	Increased	Decreased	Same
ALL PHYSICIANS	**15.0%**	**17.4%**	**67.6%**	**15.8%**	**19.6%**	**64.6%**
Specialty						
General practice	9.3	21.0	69.7	11.1	22.8	66.1
Family practice	13.6	20.6	65.8	13.2	24.2	62.6
Internal medicine	14.0	17.5	68.5	13.7	20.2	66.1
Cardiology	22.5	21.3	56.2	23.8	22.5	53.7
Other medical specialties	13.5	14.1	72.4	13.5	13.5	73.0
General surgery	15.9	15.9	68.1	15.9	18.1	65.9
Orthopedic surgery	13.8	13.8	72.4	15.5	10.3	74.1
Ophthalmology	12.4	20.6	67.0	11.3	22.7	66.0
Urology	14.9	10.8	74.3	16.2	13.5	70.3
Obstetrics/gynecology	19.5	11.7	68.8	19.5	15.6	64.9
Other surgical specialties	20.1	13.2	66.7	20.8	16.7	62.5
Anesthesiology	15.1	19.7	65.1	20.2	19.3	60.5
Radiology	14.6	20.8	64.6	16.0	25.5	58.5
Practice Arrangement						
Self-employed	14.2	17.8	68.0	14.9	19.9	65.2
Employed by:						
Hospital or university	20.5	11.6	67.9	20.5	14.3	65.2
Clinic or HMO	21.6	12.7	65.7	22.4	12.7	64.9
Another physician or corporation	14.7	18.4	66.8	16.3	23.7	60.0

Source: 1987 Physicians' Practice Follow-up Survey.

TABLE 4-3

AVERAGE LIMITS ON MALPRACTICE INSURANCE COVERAGE, 1983-1986

	AVERAGE PER CASE LIMIT			AVERAGE TOTAL LIMIT		
	1983	1986	% Change	1983	1986	% Change
ALL PHYSICIANS	**$984,414**	**$1,054,767**	**7.1%**	**$2,266,770**	**$2,435,215**	**7.4%**
Specialty						
General practice	665,468	827,698	24.4	1,543,165	1,788,489	15.9
Family practice	848,727	957,116	12.8	1,862,547	2,167,605	16.4
Internal medicine	922,600	917,600	-0.5	2,298,400	2,466,820	7.3
Cardiology	1,188,971	1,384,559	16.5	2,783,088	2,962,500	6.4
Other medical specialties	844,813	881,381	4.3	2,166,045	2,376,119	9.7
General surgery	896,358	946,689	5.6	2,091,722	2,196,689	5.0
Orthopedic surgery	1,063,725	1,129,412	6.2	2,491,176	2,541,176	2.0
Ophthalmology	990,854	1,148,171	15.9	2,265,854	2,686,585	18.6
Urology	1,097,015	1,123,134	2.4	2,211,940	2,274,627	2.8
Obstetrics/gynecology	1,084,341	1,057,703	-2.5	2,475,275	2,395,615	-3.2
Other surgical specialties	1,261,441	1,167,373	-7.5	2,781,780	2,671,610	-4.0
Anesthesiology	1,161,277	1,257,065	8.2	2,519,022	2,754,891	9.4
Radiology	1,066,910	1,255,674	17.7	2,479,213	2,730,899	10.2
Practice Arrangement						
Self-employed	959,434	1,018,793	6.2	2,202,658	2,366,537	7.4
Employed by:						
Hospital or university	858,108	1,043,243	21.6	2,441,892	2,678,378	9.7
Clinic or HMO	1,261,348	1,317,528	4.5	2,765,169	2,930,337	6.0
Another physician or corporation	1,135,063	1,266,038	11.5	2,563,522	2,761,635	7.7

Source: 1987 Physicians' Practice Follow-up Survey.

5.0 CHANGES IN PHYSICIAN PRACTICE PATTERNS DUE TO MALPRACTICE INSURANCE COSTS

5.1 Introduction

A great deal of attention has recently been focused on the way in which the medical malpractice system is working. One of the major concerns has been with the availability of insurance, whereby certain physicians may be unable to obtain malpractice insurance. In such cases, physicians may decide not to treat certain types of cases or procedures, or to enter certain specialties. As a result, insurance availability problems may translate into patient access-to-care problems.

Another concern has been the cost of malpractice insurance premiums, a very visible component of the system. Our findings in Chapter 3 show that premiums have increased 75 percent from 1983 to 1986. However, examining the cost of premiums is not in itself a good indicator of the full cost to society of medical malpractice. By far the most significant cost of medical malpractice, as Danzon (1985) has pointed out, is the lost production and welfare of those people who suffer medical injury.

Other costs are also concealed within the system. Perhaps the largest of these is the cost of "defensive medicine," which refers to the resources devoted to reducing the risk of malpractice suits (such as the ordering of additional tests to reassure a patient, or the time cost of taking more detailed records) rather than improving the quality of health care. Of course, resources are also tied up in litigation (i.e., court appearances, bringing and defending actions).

Faced with the high cost or unavailability of malpractice insurance, physicians may change their practice patterns. This is particularly likely due to the unequal cost increases across specialties (shown in Chapter 3). This chapter presents detailed data on the extent to which physicians have discontinued performing certain procedures or seeing certain cases to reduce the incidence of malpractice claims.

As discussed in Section 2.3, physicians were asked a series of questions about problems with the availability of malpractice insurance and the nature of changes in procedures performed or cases treated. Physicians' verbatim responses were coded for purposes of analysis (see Section 2.4 and Appendix A). Section 5.2 looks at the problems encountered with the cost and availability of malpractice insurance. Section 5.3 looks at changes in physician practice patterns (i.e., the discontinuation of high risk procedures and certain cases). Section 5.4 examines the impact by specialty and practice arrangement.

5.2 Perceived Problems With The Availability of Malpractice Insurance

When a physician experiences a lack of availability of insurance it usually means one of two things: either the insurance is available, but only at a price the physician is unwilling to pay, or it is unavailable at any price.

Danzon (1985) states, "There is currently no general lack of insurance except in states in which rates are heavily regulated to levels that insurance carriers deem inadequate for the risks involved." In other words if insurance companies could raise prices sufficiently to cover anticipated costs there would be no supply shortage. Whatever the underlying reasons however, individual physicians have in the past been confronted with complete lack of availability. It is for this reason that many states have established Joint Underwriting Associations(JUAs). For instance, in Virginia a major insurance company decided not to cover physicians unless they practiced in hospitals or in groups of at least ten (American Medical News, 10/10/86). In response, the state legislature reactivated its JUA and accepted premiums from the excluded physicians.

Table 5-1 shows the nature of availability problems reported by physicians. Column (1) displays the percentage of all physicians reporting a problem, while column (2) adjusts the percentages to include only those physicians reporting one or more impacts. The first thing to note is that only 13 percent of physicians had experienced any difficulties with the availability of such insurance. The responses of those physicians who indicated they had experienced problems are broadly grouped according to the nature of the problem (i.e., cost versus availability). It is likely that some of these availability problems occurred during the malpractice "crisis" of the mid 1970s. For example, the GAO (1986a) reported that the threatened or actual withdrawal of carriers in the mid-1970s reduced the availability of medical malpractice coverage in at least nine states (Florida, New York, California, Hawaii, Massachusetts, Nevada, Maryland, Idaho, and Pennsylvania).

Of those reporting an availability problem, about half reported a problem with the availability of insurance in general. Some respondents claimed that they could no longer obtain insurance because their carrier had withdrawn from the state in which they practiced (19%):

> "Hartford pulled out of Colorado and that's it. I had to find someone else."
>
> "Empire Casualty went out of business in state of Texas three years ago and had to switch. Had to find a new carrier."

TABLE 5-1

PERCEIVED PROBLEMS WITH THE AVAILABILITY OF MALPRACTICE INSURANCE[a,b]

	Percent of All Physicians (1)	Percent of Physicians Indicating Problems (2)
INSURANCE NOT AVAILABLE (General)		
Withdrawal of carrier from state	2.5%	18.5%
State/medical society formed company	1.1	8.3
Denial/cancellation by one or more carriers	1.6	12.2
Not enough carriers to choose from	1.0	8.1
Part-time MDs not covered	0.1	0.6
SUBTOTAL	6.3	47.8
TYPE OF INSURANCE NOT AVAILABLE		
Limit on extent of coverage	0.9	7.0
Certain procedures or specialty not covered	0.6	4.3
Umbrella coverage not available	0.2	1.2
Desired coverage not available	0.6	4.6
Limit on practice size	0.1	0.6
SUBTOTAL	2.4	17.7
COST OF INSURANCE		
High cost - general	2.0	15.8
High cost for obstetrics	0.1	0.5
High cost for older MDs	c	0.2
SUBTOTAL	2.1	16.4
OTHER		
Problem more than 5 years ago	1.4	11.0
Other/uncodeable	0.8	7.1
SUBTOTAL	2.2	18.1
TOTAL	**13.0**	**100.0**

Source: 1987 Physicians' Practice Follow-up Survey.

[a]Refer to Appendix A for Verbatim Coding Scheme.

[b]Inconsistencies between columns (1) and (2) are due to rounding.

[c]Less than 0.05 percent.

Other physicians had been denied coverage or had their policies cancelled by one or more carriers (12%).

> "I have three suits that the company settled for $8,000 and they dropped me."
>
> "Cancelled by one and difficulty getting another."
>
> "The company I was with dropped me and I had to pick up insurance from someone else."
>
> "It was cancelled because of a law suit." "When reporting a case to the carrier once, I was dropped and had to find another company."
>
> "I had two law suits and I won the first one, and with the second one they wanted to drop me three days before my court date."
>
> "I was dropped by my carrier and assigned to a risk group which is much more expensive."

Another 8 percent indicated that they had experienced an availability problem but they were now obtaining coverage through a state run company (Joint Underwriting Association) or a company formed by a medical society.

> "The insurance companies went out of business here and dropped everyone and we had to start our own company."
>
> "In New York state, a couple of years ago insurance companies abandoned malpractice insurance. New York state medical society helped organize an insurance company that provided malpractice to physicians and I subscribed to that."

Six percent indicated there were not enough carriers to choose from.

> "I have no choice. Lack of choice is a limitation. Only one company writing insurance. Changed insurance coverage but didn't cut premium and have to renew each year."
>
> "There's no competition in the state of Utah."
>
> "Aren't many places that you can get insured. Only one or two that will insure."

The second most frequently reported problem was <u>availability of the preferred type of insurance</u>. Within this category, 7 percent of physicians experienced a problem with limits on the extent of coverage. Examples of the verbatim responses are:

"Insurance company that used to insure me for over the coverage limit doesn't do it anymore. I can't get that extra coverage now."

"I had to change carriers because they did not carry a $200,000 coverage, they only carried a 100,000 and I wanted a $200/$600."

In a similar vein, other physicians complained they were unable to obtain the type of insurance they wanted (e.g., occurrence policy). Together these responses represent about 6 percent of the physicians experiencing some kind of problem. For example:

"I can't get occurrence insurance anymore, only claims made."

"I can no longer get occurrence coverage and I had to get a claims made policy."

About 4 percent of physicians who had experienced problems indicated that they had found it difficult to obtain insurance for certain procedures or specialties. As can be seen from a selection of the verbatim responses, several were engaged in providing obstetrical care:

"The insurance company that I had cancelled because I was handling obstetrics and they didn't cover obstetrics so I had to change."

"The company we were insured with stopped doing obstetrics so I had to change."

"This year I had difficulty obtaining coverage because I see pregnant women as a urologist."

The high cost of insurance was explicitly mentioned by 16 percent of the respondents who had experienced problems.* Virtually all of these referred to high cost generally:

"There are only two insurance companies here and St. Paul is leaving and the other is much more expensive."

"They don't want to insure you. They want too much money."

"Trying to find a civilized insurance company. I was upset by the costs."

*Respondents were asked if they had experienced problems with the availability of insurance. Had we asked physicians whether they considered the cost of insurance to be a problem, the number of affirmative responses clearly would have been much higher.

Physicians in two specialties -- obstetrician/gynecologists and anesthesiologists -- most frequently mentioned the cost of insurance to be a problem.

5.3 Changes in Practice Patterns

One of the main issues underlying the medical malpractice debate is whether problems with the cost or availability of insurance have led physicians to modify their practice patterns to reduce the risk of being sued. Danzon (1985) notes that the existing tort fault-based system gives physicians the incentive to improve the care they deliver to reduce the chance of being sued. Among the benefits produced by defensive medicine are (1) insuring health care consumers against bad medical practice; and (2) regulating a minimum standard of care (Danzon, 1985).

Of course, the adoption of defensive medicine is as much a response to the perceived risk of suits as to increases in the cost of insurance. The literature distinguishes between "positive" and "negative" defensive medicine. Gonzales (1986) defines these terms as follows:

> "Positive defensive medicine" occurs when a physician performs additional tests or procedures in order to avoid being accused of negligence (for not having performed them) and not because they are perceived as essential. This type of defensive medicine directly increases health care costs. The second type, termed "negative defensive medicine," occurs when a physician avoids certain procedures because legal risks might arise from resulting complications.

Most of the previous research has focused on positive defensive medicine strategies. Zuckerman (1984), for example, found that physicians are indeed taking certain precautions in their day to day practice. The most common responses were: increasing record-keeping (57%), increasing patient referral (45%), performing additional testing (41%), and spending more time with patients (36%). Some of the actions which have been called "defensive medicine" might possibly be viewed as the result of physician income-maximizing behavior.

Similarly, Paxton (1986) reports that physicians involved in obstetrics are adopting one or more defensive tactics: ordering more tests (66%); telling patients about risks (49%); keeping more detailed records (37%); and obtaining more consultations (37%).

The Physicians' Practice Follow-up Survey asked physicians about two aspects of negative defensive medicine practices -- the discontinuation of certain procedures or cases. Of particular concern with the adoption of negative defensive medicine is the impact on access to care.

5.3.1 Discontinuation of "High-Risk" Procedures

Overall, 14 percent of physicians discontinued performing one or more "high-risk" procedures in the past year due to malpractice insurance costs.* Table 5-2 shows the high-risk procedures which were discontinued by the sample physicians. We have grouped the responses into broad categories based on the level of complexity of the procedure. The most common discontinued procedure was obstetrics, which accounted for 24 percent of the responses indicating a problem. This includes both general obstetrics (17%) and high-risk obstetrics (7%). Examples of responses are:

OBSTETRICS

"We have given up obstetrics only."

"Try to avoid obstetrical anesthesia."

HIGH-RISK OBSTETRICS

"I'm less inclined to take high risk OBs, and no infertility."

"Diabetic patients."

"All the OB with complications, hypertension with pregnancy, diabetes."

The responses varied by specialty: three-fourths of those discontinuing general obstetrics were family and general practitioners. Three-fourths of those discontinuing high-risk obstetrics were OBGs.

Returning to Table 5-2 we can see that about one-fifth (21%) of respondents reporting problems discontinued some kind of major surgery (these physicians represent 3% of all physicians). The most common of these was orthopedic surgery which accounted for 5 percent, plastic surgery and cardiovascular surgery were discontinued by 2 percent each.

The responses from some physicians were more general in nature and indicated they had discontinued all surgery, some surgery, surgical assisting or office surgery. The total for these responses was 19 percent, with all surgery accounting for 9 percent.

Of the two percent of physicians who discontinued all or some surgery (see Table 5-2) general and family practitioners accounted for two-thirds.

---

*Respondents were asked if they had discontinued certain high risk procedures. Because of the open-ended nature of the questionnaire each respondent placed his or her own interpretation on the meaning of the term "high-risk." See section 2.3 and Appendix A for details of the verbatim coding.

TABLE 5-2

HIGH-RISK PROCEDURES DISCONTINUED AS A RESULT OF MALPRACTICE INSURANCE COSTS[a,b]

	Percent of All Physicians (1)	Percent of Physicians Indicating Problems (2)
OBSTETRICS		
Obstetrics (general)	2.3%	16.6%
High risk obstetrics	1.1	6.9
SUBTOTAL	3.3	23.5
SURGERY - GENERAL		
All surgery	1.2	8.5
Some surgery	0.7	4.9
Surgical assisting	0.6	4.4
Office surgery	0.1	0.9
SUBTOTAL	2.7	18.5
MAJOR SURGERY		
Orthopedic	0.9	5.4
Plastic	0.3	2.1
Cardiovascular	0.3	2.0
Urological	0.1	1.5
Abdominal	0.2	1.4
Head and neck	0.3	1.4
Hand	0.2	1.2
Gynecological	0.1	1.0
ENT	0.2	0.8
Thoracic	c	0.3
Other	0.7	4.3
SUBTOTAL	3.3	21.4
MINOR SURGERY		
Cardiovascular	0.5	4.1
Fertility/infertility	0.4	3.0
Eye surgery	0.3	2.2
Arthrocentesis, paracentesis, thoracentesis, amniocentesis	0.2	1.1
Lumbar punctures	0.1	0.9
SUBTOTAL	1.5	11.3
OTHER PROCEDURES/SERVICES		
Biopsies	0.5	3.5
Orthopedics (non-surgical)	0.4	2.7
Endoscopies	0.3	1.7
Pediatrics	0.2	1.5
Emergency room services	0.2	1.0
Accidents and trauma	c	0.1
SUBTOTAL	1.6	10.4
OTHER		
All high risk	0.6	4.0
Medicaid and indigent	0.1	0.5
Other/uncodeable	1.4	10.3
SUBTOTAL	2.1	14.9
TOTAL	**14.4**	**100.0**

Source: 1987 Physicians' Practice Follow-up Survey.

[a]Refer to Appendix A for Verbatim Coding Scheme.

[b]Inconsistencies between columns (1) and (2) are due to rounding.

[c]Less than 0.05 percent.

The remaining groups we have defined represent minor surgery and procedures. They account for 12 percent and 9 percent of responses, respectively. Examples are: minor cardiovascular surgery (4% of responses), fertility/infertility services (3%), eye surgery (2%), biopsies (4%), and minor orthopedic procedures (3%).

A small number of respondents indicated that they had dropped "all high-risk" procedures, in general, and an even smaller percentage said they would not see Medicaid or indigent patients.

5.3.2 Discontinuation of Cases

Table 5-3 shows the types of cases that were discontinued by the physicians in our sample. As before we have recoded all of the responses into broad groups (see Appendix A). Once again this reveals that obstetrics and high-risk obstetrics appear to have been affected more than any other single element of medical practice by malpractice insurance costs. The responses also indicate that physicians are dropping other surgical and medical cases. This is perhaps an area where there is some confusion as to what constitutes a case versus a procedure, and is an area where some overlap occurs between this section and the previous section. However, one group which does not overlap, and which is significant is patient characteristics. This refers to non-medical reasons given by physicians for refusing to see certain cases. To some respondents these characteristics are indications that the patient represents a litigation risk.

The most commonly cited reasons for refusing to see a case relate to non-medical characteristics of patients. As can be seen in Table 5-3, 35 percent of responses fell into this broad category. Two types of patients were most affected: patients involved in litigation (11%), and Medicaid and indigent patients (11%). Litigious patients include those involved in malpractice suits, or presenting a risk to the physician:

> "People with previous malpractice suits or obviously hostile attitude."
>
> "I tell patient if it's a legal case I will not see them. I'll treat their medical problem but their legal problem -- no. One has no idea how long these legal things take. I've lived so long -- the patients in my day had no idea to sue a doctor -- if it didn't turn out, they knew the doctor did the best."
>
> "Seeing foreign language patients. That's part of the reason."

TABLE 5-3

TYPES OF CASES DISCONTINUED AS A RESULT OF MALPRACTICE INSURANCE COSTS[a,b]

	Percent of All Physicians (1)	Percent of Physicians Indicating Problems (2)
PATIENT CHARACTERISTICS		
Patients involved in litigation	1.3	11.4
Medicaid and indigent	1.2	11.3
Medicare	c	0.4
All high risk	0.5	4.7
Increased referrals	0.3	3.2
Other patient characteristics	0.6	4.4
SUBTOTAL	4.1	35.4
PROCEDURES/SERVICES		
Emergency room services	0.6	5.6
Accidents and trauma	0.4	3.9
Pediatrics	0.4	3.7
Cardiovascular procedures (non-surgical)	0.3	2.9
Endoscopies	0.2	1.3
Other procedures	0.7	6.6
SUBTOTAL	2.6	24.0
OBSTETRICS		
Obstetrics (general)	1.5	13.7
High risk obstetrics	0.9	7.7
SUBTOTAL	2.4	21.5
SURGERY		
Some surgery	1.5	12.5
All surgery	0.2	1.6
Surgical assisting	0.1	0.4
SUBTOTAL	1.8	14.5
Other/uncodeable	0.4	4.7
TOTAL	11.2	100.0

Source: 1987 Physicians' Practice Follow-up Survey.

[a]Refer to Appendix A for Verbatim Coding Scheme.

[b]Inconsistencies between columns (1) and (2) are due to rounding.

[c]Less than 0.05 percent.

Physicians offered the following reasons for refusing to treat Medicaid patients:

> "Yes, Medicaid cases. They are ridiculous, we take a ridiculous loss on these cases. They pay $200 on colorectal surgery cases that are a $1,500 procedure and these are the type of cases that can have complications and are prone to sue."
>
> "Stop seeing Medicaid because of chances of being sued."

We examined the specialty breakdowns for these two patient characteristics and found that surgeons were most likely to refuse patients involved in litigation, although the reader is reminded that only 1.3 percent of all physicians refused to treat patients involved in litigation. Both surgeons and primary care physicians were likely to deny services to Medicaid patients. Again, the reader is reminded that 1.2 percent of physicians refused to see such patients. About one-fifth of these physicians were OBGs. Of the OBGs who said they had discontinued certain cases, 26 percent had discontinued seeing Medicaid patients. These findings raise questions about the extent to which physicians' decisions are motivated strictly by rising insurance costs or are also based, for example, on the level of Medicaid payments for obstetrical or other services.

Three-fourths of <u>all</u> physicians refusing to see Medicaid patients practiced in urban areas, and one-fourth practiced in rural areas (compared to 16 percent of the entire sample residing in rural areas). These findings suggest that physicians' problems with malpractice insurance may adversely affect access to care for certain groups within the population, such as the rural poor. Of particular concern is the availability of prenatal care in rural areas for the high-risk low-income population.

5.4 Differences by Specialty and Practice Arrangement

Do availability problems and practice impacts vary by specialty or practice arrangement? As shown in Table 5-4, the percentage of physicians who reported problems with insurance availability varies slightly by specialty. At the high end were obstetrician/gynecologists with nearly 20 percent, orthopedic surgeons with 19 percent, and other surgical specialists with 17 percent. Interestingly, these are the same specialties with the highest own malpractice insurance premiums, on average (see Section 3.3). Radiologists and other medical specialists were least likely to report availability problems. These specialties had relatively low premiums on average.

In terms of employment status of responding physicians, the group most commonly reporting problems with cost or availability were self-employed physicians. Nearly 15 percent said they had experienced problems in the last

TABLE 5-4

AVAILABILITY PROBLEMS AND PRACTICE IMPACTS, BY SPECIALTY AND PRACTICE ARRANGEMENT[a]

	PERCENT OF ALL PHYSICIANS WHO HAVE:		
	Had Problems With Availability of Insurance	Discontinued Certain Procedures Due to Cost of Insurance	Discontinued Certain Cases Due to Cost of Insurance
ALL PHYSICIANS	**13.0%**	**14.4%**	**11.2%**
Specialty			
General practitioners	12.1	27.0	14.9
Family practitioners	13.2	25.5	14.1
Interal medicine	10.7	10.1	7.6
Cardiologists	10.1	6.7	6.7
Other medical specialists	8.3	2.1	3.6
General surgeons	13.6	21.0	16.5
Orthopedic surgeons	19.2	22.1	16.4
Ophthalmologists	14.6	11.5	12.5
Urologists	13.6	12.0	15.2
Obstetrician/gynecologists	19.5	18.1	18.1
Other surgical specialists	17.2	14.9	20.2
Anesthesiologists	15.2	5.9	5.5
Radiologists	9.2	5.6	1.6
Practice Arrangement			
Self-employed	14.5	16.0	12.4
Employed by:			
Hospital or university	5.5	6.9	5.5
Clinic or HMO	7.1	5.4	5.4
Another physician or corporation	11.2	7.0	6.1

Source: 1987 Physicians' Practice Follow-up Survey.

[a]Refer to Appendix A for Verbatim Coding Scheme.

year, compared to only 6 percent of hospital employees. Presumably, hospital employees do not perceive malpractice insurance availability to be as large a problem because their premiums may be paid in whole or in part by the hospital (or through a self-insurance program).

Variation across specialties is much more pronounced with respect to practice impacts. Over one-quarter of both family practitioners and general practitioners indicated they had discontinued certain procedures because of malpractice insurance costs. Orthopedic surgeons at 22 percent, and general surgeons at 21 percent also responded at a rate well above the average (14%). Well below the average were cardiologists, other medical specialists, radiologists, and anesthesiologists. Once again, self-employed physicians were more likely to experience problems than employed physicians.

Other surgical specialists (20%) and OBGs (18%) were most likely to discontinue seeing certain cases. Among employment categories, self-employed physicians were most likely to drop certain cases because of the cost of insurance.

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APPENDIX A

VERBATIM RESPONSE CATEGORIES FOR OPEN-ENDED QUESTIONS

TABLE A-1

VERBATIM RESPONSE CATEGORIES: HAVE YOU EVER HAD PROBLEMS WITH THE AVAILABILITY OF MALPRACTICE INSURANCE?

- Withdrawal of Carrier From State

  "Hartford pulled out of Colorado and that's it. I had to find someone else."

  "I had insurance with Physicians' Liability Insurance company and they went out of business; they sent us a letter saying this."

  "Former insurance company pulled out."

  "Empire Casualty went out of business in state of Texas three years ago and had to switch. Had to find a new carrier."

- State/Medical Society Formed Company

  "The insurance companies went out of business here and dropped everyone and we had to start our own company."

  "My insurance carrier went out of business so I had to go to the state."

  "I was cancelled by Fort Wayne and I got it through Illinois State Medical Society."

  "Not since the state formed its own company (Tennessee)."

  "No commercial insurance company would write it. We got around it by starting our own insurance company."

  "Main insurer in state decided not to insure for some reason. It spawned in Arizona a new company by doctors."

  "In New York state, a couple of years ago insurance companies abandoned malpractice insurance. New York state medical society helped organize an insurance company that provided malpractice to physicians and I subscribed to that."

- Denial by One or More Carriers (Cancellation)

  "I have three suits that the company settled for $8,000 and they dropped me."

  "Cancelled by one and difficulty getting another."

  "The company I was with dropped me and I had to pick up insurance from someone else."

  "It was cancelled because of a law suit."

  "When reporting a case to the carrier once, I was dropped and had to find another company."

TABLE A-1 (continued)

VERBATIM RESPONSE CATEGORIES: HAVE YOU EVER HAD PROBLEMS WITH THE AVAILABILITY OF MALPRACTICE INSURANCE?

- Denial by One or More Carriers, continued

  "I had to go to three different carriers last year."

  "Right now I can't get it. Have one case pending."

  "In 1985, Colorado dropped me from insurance. They had a judgment against me."

  "I had two law suits and I won the first one, and with the second one they wanted to drop me three days before my court date."

  "I was dropped by my carrier and assigned to a risk group which is much more expensive."

- Not Enough Carriers to Choose From

  "My malpractice went out of business and I had to find another company and there aren't very many of them."

  "If you're not a member of the medical society there is none available, there's only one writing policies for new policies."

  "In Hawaii, we only have one carrier and we had a problem with availability for about 3 months."

  "I have no choice. Lack of choice is a limitation. Only one company writing insurance. Changed insurance coverage but didn't cut premium and have to renew each year."

  "Not enough companies to choose from."

  "There's no competition in the state of Utah."

  "Aren't many places that you can get insured. Only one or two that will insure."

- Part-Time MDs Not Covered

  "In 1984 I was working part-time, I couldn't find a company to insure part-time physicians."

- Limit on Extent of Coverage

  "I had to change carriers because they did not carry a $200,000 coverage, they only carried a $100,000 and I wanted $200k/$600k."

  "There are no choices only one insurance. Liability limits are too low, can't get any more."

TABLE A-1 (continued)

VERBATIM RESPONSE CATEGORIES: HAVE YOU EVER HAD PROBLEMS WITH THE AVAILABILITY OF MALPRACTICE INSURANCE?

- Limit on Extent of Coverage (continued)

  "There are only two carriers in Michigan. They would only provide $200k/$600k coverage."

  "Problem with OB care because we couldn't get adequate level of coverage."

  "Insurance company that used to insure me far over the coverage limit doesn't do it any more. I can't get that extra coverage now."

- Certain Procedures or Specialty Not Covered

  "The insurance company that I had cancelled me because I was doing obstetrics and they didn't cover obstetrics so I had to change."

  "The company we were insured with stopped insuring obstetrics and we had to go to another company."

  "They don't like to write OB or they the carriers don't like to write OB policies."

  "One co-op refused to sign up OBG's who performed high-risk operations."

  "This year I had difficulty obtaining coverage because I see pregnant women as a urologist."

- Umbrella Coverage not Available

  "We can't get it. Most we can get is $200k/$600k. No umbrella policy available."

  "My umbrella was cancelled. We couldn't get it. It was cancelled for everybody."

- Desired Coverage not Available (General)

  "I wanted to get back to Illinois state insurance in the middle of 1986 from St. Paul, but they refused to except me unless I pay the tail coverage for two years."

  "I can't get occurrence insurance anymore, only claims made."

TABLE A-1 (continued)

VERBATIM RESPONSE CATEGORIES: HAVE YOU EVER HAD PROBLEMS WITH THE AVAILABILITY OF MALPRACTICE INSURANCE?

- Limit on Practice Size

  "The doctor is being dropped by Philco because he is in solo practice, all doctors in this state who are in solo practice are being dropped. You have to be in a group of about 10 or more. So far this is the state of Virginia only."

- High Cost-General

  "The company cancelled us then reinstated us. No, other than high premiums."

  "There are only two insurance companies here and St. Paul is leaving and the other is much more expensive."

  "They don't want to insure you. They want too much money."

  "Only the prices (too high)."

  "The rates keep going up and the insurance company keeps threatening to drop unless you pay the price."

  "We had to change company every year because they are increasing the rates every year."

  "We had to find a company that we could afford. The cost was going up but the service was poor. They kept decreasing the coverage."

  "The only reason we broke off from the hospital was to form our own practice because malpractice became unaffordable."

  "Trying to get a civilized insurance company. I was upset by the costs."

- High Cost for OB

  "Only for obstetrical care. They want to multiply my premium by five if I want to continue practicing OBGYN."

- High Cost for Older MDs

  "The company that I was with quit writing physicians. I can get another insurance but it is too expensive for MDs over 65. Insurance is the biggest problem we have right now."

TABLE A-1 (continued)

VERBATIM RESPONSE CATEGORIES: HAVE YOU EVER HAD PROBLEMS WITH THE AVAILABILITY OF MALPRACTICE INSURANCE?

- Problem More Than Five Years Ago

  "In 1976, 77 and 78, it was not available in Alaska for the entire state."

  "13 years ago, I had a problem with availability. I was in a group and there were some legal suits and it was hard to get insured."

  "I was using Lloyds of London as my insurance company way back, and the malpractice insurance rates were reasonable. But they didn't want us to use foreign companies so I was forced to change."

- Other

  "The entire state had problems in 1986 due to a controversy over tort reform in the state legislature -- my company cancelled all policies in the state until they repealed portions of the tort reform."

  "Doctor said she is a nutritionist, and the AMA does not like what she is doing."

  "I'm in Florida, and we had a problem about 2 years ago."

  "Obtaining malpractice insurance for the group, not for myself personally, but for the group."

TABLE A-2

VERBATIM RESPONSE CATEGORIES: SINCE THIS TIME LAST YEAR HAVE YOU DISCONTINUED PERFORMING CERTAIN HIGH RISK PROCEDURES BECAUSE OF MALPRACTICE COSTS?

- Obstetrics

  "All obstetrics."

  "We have given up obstetrics only."

  "Try to avoid obstetrical anesthesia."

- High Risk Obstetrics

  "I'm less inclined to take high risk OBs".

  "Diabetic patients."

  "All the OB with complications, hypertension with pregnancy, diabetes."

- All Surgery

  "All surgical procedures."

  "Quit performing surgeries."

  "All operating."

- Some Surgery

  "Some surgeries, gall bladder surgery, hysterectomy, hernia surgery."

  "I quit doing all surgical procedures except for laser surgery."

  "Radical cystectomies, radical prostatectomies, penile implants, certain pediatric procedures,..."

  "I don't do as much surgery, less surgery; it would be minor surgery but I do less, refer them, that's all."

  "Retractive surgery."

- Surgical Assisting

  "All surgical assisting."

- Office Surgery

  "I don't do any more office surgery, I assist other doctors."

TABLE A-2 (continued)

VERBATIM RESPONSE CATEGORIES: SINCE THIS TIME LAST YEAR HAVE YOU DISCONTINUED PERFORMING CERTAIN HIGH RISK PROCEDURES BECAUSE OF MALPRACTICE COSTS?

- Major Surgery - Orthopedic

  "Any spinal fusions, congenital hip dislocations, club foot."

  "I've stopped doing spinal fusion and total hip replacement."

  "Back surgery."

  "All spinal surgery."

- Major Surgery - Plastic

  "Elective cosmetic."

  "Certain plastic surgery procedures. The high risk ones. I don't want to have to think about specific ones."

  "Cosmetic surgery."

- Major Surgery - Cardiovascular

  "Vascular surgery."

  "Major vascular cases."

- Major Surgery - Urological

  "Penile prosthesis."

  "Prostheses for impotence, radical surgery. We give those problems to the university hospital."

- Major Surgery - Abdominal

  "Abdominal surgery."

- Major Surgery - Head and Neck

  "Cancer work head and neck only."

  "Neck surgery because of high risk in malpractice."

- Major Surgery - Hand

  "Surgical repair of hands because of the great concern of malpractice."

  "Replantation, repatching of the hand."

TABLE A-2 (continued)

VERBATIM RESPONSE CATEGORIES: SINCE THIS TIME LAST YEAR HAVE YOU DISCONTINUED PERFORMING CERTAIN HIGH RISK PROCEDURES BECAUSE OF MALPRACTICE COSTS?

- Major Surgery - Gynecology

  "Mostly gynecological. Hysterectomies."

  "Mostly those to do with female pelvis and its contents."

- Major Surgery - Ear, Nose and Throat

  "Stapedectomy ear surgery."

  "Stapedectomies, that's the main one."

- Major Surgery - Thoracic

  "Complicated thoracic."

  "Surgical procedure for thoracic outlet decompression."

- Major Surgery - Other

  "Gastric by-passes."

  "First rib resection."

  "Radical surgery."

- Minor Surgery - Cardiovascular

  "Swan Ganz catheter and arterial lines."

  "I have stopped doing catheterization and pacemaker."

  "Catheterization and angiography."

  "Angioplasty."

  "Transluminal angioplasty, certain other angiograms."

  "High-risk invasive procedures such as embolization, cerebral angiography."

  "Angiography, myelography."

- Infertility/Fertility

  "Artificial insemination, I just stopped doing that."

  "Infertility surgery."

  "I no longer do abortions."

TABLE A-2 (continued)

VERBATIM RESPONSE CATEGORIES: SINCE THIS TIME LAST YEAR HAVE YOU DISCONTINUED PERFORMING CERTAIN HIGH RISK PROCEDURES BECAUSE OF MALPRACTICE COSTS?

- Infertility/Fertility (continued)

  "Therapeutic abortions."

  "All vasectomies."

- Arthrocentesis, Paracentesis, Thoracentesis, Amniocentesis

  "Stopped doing amniocentesis."

- Biopsies

  "Liver biopsy, spinal tap, and pleural biopsy."

  "Colon biopsy."

- Orthopedic - Minor Procedures

  "Fracture work."

  "Castings, bone fractures."

  "Orthopedics such as casting and fracture management."

- Pediatrics

  "Pediatrics."

  "I cut my pediatrics practice by 90 percent."

  "Pediatrics endoscopy."

  "Complicated pediatrics such as circumcisions for children under the age of two and reno vascular surgery."

- All High Risk

  "All high risk cases."

  "I'm turning away any case that is prolonged or high risk."

  "High risk procedures."

  "I have been sending most of the high risk cases to the university hospitals, of all kinds."

- Medicaid and Indigent

  "Medicaid complicated procedures."

TABLE A-2 (continued)

VERBATIM RESPONSE CATEGORIES: SINCE THIS TIME LAST YEAR HAVE YOU DISCONTINUED PERFORMING CERTAIN HIGH RISK PROCEDURES BECAUSE OF MALPRACTICE COSTS?

- Others

  "The pain block procedures, certain nerve blocks for the treatment of chronic pain syndrome."

  "Stopped doing experimental cases."

  "Mostly blocking types of anesthesia, continues spinal anesthetics, sympathetic blocks, epidural blocks."

  "Penile prosthesis."

  "If a patient came to me with a problem that another MD caused, I would not see that patient because that MD may have a law suit pending against him."

TABLE A-3

VERBATIM RESPONSE CATEGORIES: SINCE THIS TIME LAST YEAR HAVE YOU DISCONTINUED SEEING CERTAIN TYPES OF CASES BECAUSE OF MALPRACTICE INSURANCE COSTS?

- Patients involved in litigation (obviously threatening, angry, hostile, litigation prone)

  "People with previous malpractice suits or obviously hostile attitude."

  "Only people who were difficult to get along with. I would not handle their cases."

  "Patient that may sue."

  "I tell patient if it's a legal case I will not see them. I'll treat their medical problem but their legal problem -- no. One has no idea how long these legal things take. I've lived so long -- the patients in my day had no idea to sue a doctor -- if it didn't turn out, they knew the doctor did the best."

  "Basically, any cases referred from an attorney with malpractice cases."

- Medicaid/indigent (uninsured, other public assistance)

  "Stop seeing Medicaid because of chances of being sued."

  "Any kind of public assistance. I don't care."

  "I stop with Medicaid patients, most of them are high-risk patients."

  "Stop taking certain government programs."

  "We have reduced our Medicaid and uninsured patients."

  "No new welfare cases."

  "Welfare cases, they are considered high risk."

  "New Medicaid cases."

  "Yes, Medicaid cases. They are ridiculous, we take a ridiculous loss on these cases. They pay $200 on colorectal surgery cases that are a $1,500 procedure and these are the type of cases that can have complications and are prone to sue."

- Medicare

  "Medicare cases."

  "Medicare cases. No others."

TABLE A-3 (continued)

VERBATIM RESPONSE CATEGORIES: SINCE THIS TIME LAST YEAR HAVE YOU DISCONTINUED SEEING CERTAIN TYPES OF CASES BECAUSE OF MALPRACTICE INSURANCE COSTS?

- All High Risk

  "High risk patients with a bad health history."

  "Just high risk procedures."

  "High risk medical patients."

  "Patients that require highly sophisticated procedures."

  "I avoid problem cases."

- Increased Referrals

  "I see them but refer them. There is a variety. Run the gamut of all internal medicine."

  "Referred patients that would not normally be referred."

- Other Patient Characteristics (Stricter Patient Selection)

  "Hard to say. Very selective depending on patient, what kind of family they have."

  "Seeing foreign language patients. That's part of the reason."

  "We eliminated HMO coverage and nursing home patients."

  "Stricter patient selection."

  "Patients that are not referred by physicians."

- Emergency Room

  "Try to take as little as possible of emergency room patients."

  "Emergency room."

- Accidents and Trauma

  "I don't take care of auto accidents any more, especially not new patients. That's pretty much it."

  "High risk trauma - emergency calls."

  "I've stopped all trauma (accident) surgery and compensation (on the job) cases."

  "Trauma cases. That's all. I don't see any more because of malpractice."

TABLE A-3 (continued)

VERBATIM RESPONSE CATEGORIES: SINCE THIS TIME LAST YEAR HAVE YOU DISCONTINUED SEEING CERTAIN TYPES OF CASES BECAUSE OF MALPRACTICE INSURANCE COSTS?

- Pediatrics

  "Seeing young children and babies because of my age."

  "I've limited pediatric patients pretty much."

- Cardiovascular Procedures (non-surgical)

  "Patients with heart attack."

  "Anything that has to do with severe chronic heart failure."

  "Arteriography patients."

  "Complicated cardiovascular heart disease."

- Endoscopies

  "Flexible fiberoptic sigmoidoscopy."

- Other Procedures/Conditions

  "I have stopped giving immunization shots."

  "Morbid obesity."

  "I don't do X-rays. Just chest X-rays."

  "Back pain consultations only."

  "Impotence only."

  "Cancer patients."

- OB

  "Only the pregnant cases."

  "OB"

- High Risk OB

  "We are no longer going to operating rooms for C section to care for the infant."

  "Diabetics during pregnancies."

  "High risk OB from out of town referrals."

TABLE A-3 (continued)

VERBATIM RESPONSE CATEGORIES: SINCE THIS TIME LAST YEAR HAVE YOU DISCONTINUED SEEING CERTAIN TYPES OF CASES BECAUSE OF MALPRACTICE INSURANCE COSTS?

- Some Surgery

  "Cerebral aneurysms because the surgeon doesn't do them."

  "I have stopped doing head and neck surgery."

  "Cosmetic surgery."

  "Retina cases, unless it is very straightforward, I won't do it."

  "Esophageal cases don't operate on hiatus hernias, pancreatic tumors."

  "No back surgery."

  "Mostly orthopedic surgery such as the back and hand, bone surgery."

  "Orthopedic procedures such as hips, total joint replacements and hand cases."

- All Surgery

  "All cases requiring surgery or treatment other than therapy or medication."

  "No more surgical cases."

  "All general surgery."

- Surgical Assisting

  "I don't assist in surgery any more."

- Other

  "Only problem is staying at class one status and being able to go to Class 2."

  "No more hospital work."